

**INSTRUCTIONS FOR COMPLETING AN APPLICATION TO PRACTICE AS A  
RESPIRATORY THERAPIST IN VIRGINIA**

*(This form has been designed to be used as a checklist when preparing to submit your application.)*

***APPLICATION FEES ARE NONREFUNDABLE***

**BEFORE YOU PROCEED, READ THE FOLLOWING POINTS CAREFULLY!**

This is the application for a full and unrestricted license to practice Respiratory Therapy in Virginia. The Board recommends that you complete this application when applying for Board Certification.

You should familiarize yourself with the qualifications required for a license by reviewing the laws and regulations governing the practice of Respiratory Therapy in Virginia. They can be found at:

[http://www.dhp.virginia.gov/medicine/medicine\\_laws\\_regs.htm](http://www.dhp.virginia.gov/medicine/medicine_laws_regs.htm)

The Board works as efficiently as possible to process applications. The time from filing an application with the Board until the issuance of a license is dependent upon entities over which the Board has no control. It is the applicant's responsibility to ensure that outside entities send the necessary documentation to the Board.

The Board provides an electronic checklist for your convenience in tracking your application. You should allow approximately 10 business days for your application checklist to be first updated on the Board's website.

Supporting documentation will be added to your checklist as it is received. Processing of documents may take up to 10 business days after they are received. If you find your checklist does not exist or does not indicate necessary documents have been received, e-mail the Board at [medbd@dhp.virginia.gov](mailto:medbd@dhp.virginia.gov), with "Respiratory Therapist Application Question" in the subject line. E-mails will be answered within 2 business days.

Your application checklist may be viewed by logging into your application and clicking on the "View Checklist" link located in the Pending Licenses section. This link will not be visible for applicants who have not yet paid the application fee. If you have submitted your application and required fee online, but no longer see your checklist in the Pending Licensing section, your license may have been issued by the Board. Before calling the Board, please visit <https://dhp.virginiainteractive.org/Lookup/Index> to view your newly issued license. This website is primary source license verification that meets the Joint Commission's requirements for license verification. If you need technical assistance with your checklist contact the agency's helpdesk at 804-367-4444. The helpdesk cannot provide assistance regarding information about your documents.

The Board of Medicine discourages the use of the United States Postal Service to send documents. If possible, and if noted below, you are encouraged to have your documents sent by pdf attachment, FAX, FED EX or UPS. The Board is unable to trace documents not delivered by the post office.

Supporting documentation sent to the Board when there is no application on file will be purged after six months.

NB: Virginia law considers material misrepresentation of fact in an application for licensure to be a Class 1 misdemeanor. Misrepresentation may be by commission or omission. Be sure of your facts and provide full responses to the Board's questions.

PROCEEDING TO THE APPLICATION SIGNIFIES THAT YOU HAVE READ AND ACCEPT THE FOREGOING PRINCIPLES REGARDING THE BOARD'S PROCESSES.

1 **Complete the online application** <https://www.license.dhp.virginia.gov/apply/>, which includes paying the nonrefundable application fee of \$130.00. Application fees may only be paid using Visa, MasterCard or Discover.

2 **Credential Verification**

An applicant for a license to practice as a respiratory therapist shall provide original source documentation (not a copy) of **one** of the following:

1. Current credential as a Certified Respiratory Therapist (CRT) or a Registered Respiratory Therapist (RRT) from the National Board of Respiratory Care (NBRC) <https://www.nbrc.org/credentialed-practitioners/>; or

2. Graduation from an accredited educational program for respiratory therapists.

**Items 3-5 are not required if you have never practiced your profession and you have never held licensure in another jurisdiction.**

3 **Employment Activity (Form B) Questionnaire** – All applicants must list all activities from the date of graduation from your professional school including but not limited to internships, employment, affiliations, periods of non-activity or unemployment, observerships and volunteer service in the “Employment Activity” section of the application beginning with your first activity following professional school graduation. If you are employed by a group practice or locum tenens/traveler company, please list all locations where you have provided service or held privileges. Follow this link to obtain a Form B:

[Form B - Hospital/Employment History Questionnaire](#)

For further information related to completing Form B's please review the following guidance document before contacting the Board of Medicine: [Guidance on Completing Form B Employment Verifications, adopted December 1, 2017](#)

**Form B's sent to the Virginia Board of Medicine by the applicant will not be accepted.**

A completed Form B Activity Questionnaire or a letter of recommendation must be received from all locations of service, places of practice or professional employment, observerships, professional research positions or professional volunteer service listed for the 2 years immediately preceding application. Form B's completed by a non-medical professional may not be accepted.

**For applicants practicing as travelers, have the company you are affiliated with provide a complete list of all locations and dates where you have provided service. Form B employment verifications must be received from each location of service for the past 2 years.**

**Completed Form B's may be attached as a PDF and sent to [medbd@dhp.virginia.gov](mailto:medbd@dhp.virginia.gov), faxed to (804) 527-4426 or mailed by the person completing the document.**

**Form B's will not be accepted from the applicant.**

4 **NPDB Self Query** – Complete the online **Place a Self-Query Order form**. Be ready to provide:

- o Identifying information such as name, date of birth, Social Security number
- o State health care license information (if you are licensed)
- o Credit or debit card information for the \$4.00 fee (charged for each copy you request)

**Verify your identity.** This can be done electronically as part of your order or by completing a paper form and having it notarized. You will receive full instructions as you complete your order.

**Wait for your response.** Once your identity is verified, the NPDB will process your order. A paper copy of your response will be sent the next business day by regular U.S. mail.

The Board does not accept emailed copies of the NPDB report. When you receive your report in the mail from NPDB **DO NOT OPEN IT. Place your unopened NPDB report in an oversized envelope and forward it to the Virginia Board of Medicine. The Board recommends using Fed EX or UPS for tracking purposes. The Board of Medicine is unable to track any mail or other package that is sent via the United States Postal Service.**

**Any NPDB report received for an application not completed within 3 months of receipt of the NPDB report will have to be resubmitted.**

5 ***License Verification***

Verification of licenses to practice as a Respiratory Therapist from all jurisdictions within the United States, its territories and possessions or Canada in which you have been issued a license must be received by the Board.

**Please contact the applicable jurisdiction where you have been issued a license to practice respiratory therapy to inquire about having documentation forwarded to the Virginia Board of Medicine.** Verification must come from the jurisdiction and may be sent by email to [medbd@dhp.virginia.gov](mailto:medbd@dhp.virginia.gov), faxed to (804) 527-4426 or mailed.

**Please note:**

▶ Virginia is a direct verification state. All supporting documents must come from the original source unless specifically noted in the instructions.

▶ Applications not completed within 12 months may be purged without notice from the board.

▶ Additional information not already listed may be requested at any time during the process.

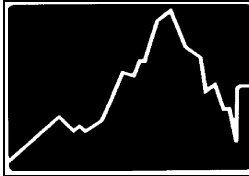
▶ Application fees are non-refundable.

▶ The Board's mailing address is **The Virginia Board of Medicine  
Perimeter Center  
9960 Mayland Drive, Suite 300  
Henrico, VA 23233**

▶ Email inquiries are normally responded to within 2 business days. Send your email inquiries to [medbd@DHP.Virginia.gov](mailto:medbd@DHP.Virginia.gov) with **Respiratory Therapy Application** in the subject line.

▶ Submission of an application does not guarantee a license. A review of your application could result in the finding that you may not be eligible pursuant to Virginia laws and regulations.

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Acupuncturist    | <input type="checkbox"/> Genetic Counselor                | <input type="checkbox"/> Osteopathy and Surgery        | <input type="checkbox"/> Radiologic Technologist           |
| <input type="checkbox"/> Athletic Trainer | <input type="checkbox"/> Medicine and Surgery             | <input type="checkbox"/> Physician Assistant           | <input type="checkbox"/> Radiologic Technologist - Limited |
| <input type="checkbox"/> BCaBA            | <input type="checkbox"/> Midwife                          | <input type="checkbox"/> Podiatry                      | <input type="checkbox"/> Radiologist Assistant             |
| <input type="checkbox"/> BCBA             | <input type="checkbox"/> Occupational Therapist           | <input type="checkbox"/> Polysomnographic Technologist | <input type="checkbox"/> Respiratory Therapist             |
| <input type="checkbox"/> Chiropractic     | <input type="checkbox"/> Occupational Therapist Assistant |  |  |



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**Virginia Department of Health Professions**

**Board of Medicine**  
9960 Mayland Drive, Suite 300  
Henrico, Virginia 23233-1463

Phone: (804) 367-4600  
Fax: (804) 527-4426  
Email: [medbd@dhp.virginia.gov](mailto:medbd@dhp.virginia.gov)

**Please provide name and address of setting/organization exactly as it appears on your application chronology.**

\_\_\_\_\_  
Clearly print/type name of applicant

Name of Setting: \_\_\_\_\_

Address: \_\_\_\_\_

Last 4 of Social Security Number XXX-XX-\_\_\_\_\_

City, State, Zip: \_\_\_\_\_

**The Virginia Board of Medicine, in its consideration of an applicant for licensure, depends on information from persons and institutions regarding the applicant's employment, training, affiliations, and staff privileges. Please complete this form to the best of your ability and return it to the Board by mail, fax or email so the information you provide can be given consideration in the processing of his/her application in a timely manner. I hereby authorize all hospitals, institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past, and present) and governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Virginia Board of Medicine any information, files or records requested by the Board in connection with the processing of my application.**

Signature of Applicant \_\_\_\_\_

1. Date and type of service: This individual served with us as \_\_\_\_\_  
from \_\_\_\_\_ to \_\_\_\_\_.  
(Month/Year) (Month/Year)

2. Please evaluate: (Indicate with check mark)

	Poor	Fair	Good	Superior
Professional knowledge				
Clinical judgment				
Relationship with patients				
Ethical/professional conduct				
Interest in work				
Ability to communicate				

3. Recommendation: (please indicate with check mark)  Recommend highly and without reservation  Recommend as qualified and competent  
 Recommend with some reservation (explain) \_\_\_\_\_  
 Do not recommend (explain) \_\_\_\_\_

4. Of particular value to us in evaluating any applicant are any notable strengths and weaknesses (including personal demeanor). We would appreciate such comments from you. \_\_\_\_\_

5. The above report is based on: (please indicate with check mark)  
 Close personal observation  General impression  A composite of evaluations  
 Other: \_\_\_\_\_

Date (Required): \_\_\_\_\_

Signed by: \_\_\_\_\_

Print or type name: \_\_\_\_\_

Signator Contact Number: (\_\_\_\_\_) \_\_\_\_\_

Title: \_\_\_\_\_